MEDICAL RADIOLOGIC TECHNOLOGIST CERTIFICATION
APPLICATION INFORMATION

PRINT or TYPE all information on the forms.

This is an application packet for Medical Radiologic Technologists. **An incomplete application will not be processed until all required fees and documents are received.**

Please allow 4 to 5 weeks for processing from the day you mail in your application (even if you mail it overnight)! After an application is received it is entered into the computer system and screened for completeness in the order in which it is received. Please be patient.

After an application is screened it will be approved, disapproved or a deficiency may be noted. Applications, which are complete, will be approved and a certificate will be sent to the applicant. Those that are disapproved or are incomplete will be sent notices listing the deficiencies or reasons for disapproval.

Each form is labeled at the bottom. All applicants MUST complete Form A, Declaration Form and the entire General Application, Form B. DO NOT leave any questions or sections blank on Form B. Put N/A if a particular item is "not applicable". ALL applicants must sign and date page 4 of Form B. NO EXCEPTIONS. The forms must be postmarked within 30 days after signing.

All applicants MUST include a RECENT color photograph (minimum 1 ½ x 1 ½). PRINT your name on the back.

FEES ARE NON-REFUNDABLE -NO EXCEPTIONS. Make certified check or money order payable to TDH.

GENERAL OR LIMITED CERTIFICATE applicants MUST include the $75.00 non-refundable application fee.

TEMPORARY GENERAL OR LIMITED CERTIFICATE applicants MUST include the $25.00 non-refundable application fee.

In accordance with Texas Occupations Code, Chapter 601, (the Medical Radiologic Technologist Certification Act), you cannot perform radiologic procedures until this application is processed and a certificate or temporary certificate is issued. The definition of a radiologic procedure includes any procedure or article intended for use in the diagnosis of disease or other medical or dental conditions in humans (including diagnostic x-rays or nuclear medicine procedures) or the cure, mitigation, treatment, or prevention of disease in humans that achieves its intended purpose through the emission of ionizing radiation.

If you only perform procedures utilizing sonography or magnetic resonance imaging (MRI), certification is not required.

Registration/Certification with the American Registry of Radiologic Technologists (ARRT), the Nuclear Medicine Technology Certification Board (NMTCB), or other national/registry or society membership of any kind does not exempt a person from the certification requirement.

TO EXPEDITE APPLICATION PROCESSING DETACH THE PAYMENT COUPON AND SUBMIT THE APPLICATION, FEE AND SUPPORTING DOCUMENTATION TO THE ADDRESS ON THE COUPON. PLEASE NO OVERNIGHT MAIL REQUIRING A SIGNATURE.

CUT ALONG THIS LINE

MRT APPLICATION PAYMENT COUPON

BUDGET: ZZ020
FUND: 124

NAME_____

SS#_____

YOU MUST RETURN
THIS COUPON WITH
YOUR APPLICATION

AMOUNT OWED: $ _____.

MAKE CERTIFIED CHECK
or MONEY ORDER
PAYABLE TO TDH.

PLEASE RETURN TO:
TDH/MEDICAL RADIOLOGIC TECHNOLOGIST CERT. PROGRAM
P. O. BOX 12197
CAPITOL STATION
AUSTIN, TEXAS 78711-2197

Receipt of payment and coupon does not constitute certification

F65-10710-Revised 01/2002

DECLARATION FORM

TEXAS DEPARTMENT OF HEALTH
MRT PROGRAM
(512) 834-6617

BUDGET ZZ020
FUND 124

APPLICANT'S NAME _____

READ CAREFULLY. USE THIS FORM TO INDICATE HOW YOU ARE QUALIFYING FOR A CERTIFICATE IN MEDICAL RADIOLOGIC TECHNOLOGY. ALL APPLICANTS MUST CHECK ONE ITEM ON THIS DECLARATION FORM & COMPLETE THE GENERAL APPLICATION FORM. SOME APPLICANTS MUST SUBMIT OTHER FORMS OR DOCUMENTATION. READ CAREFULLY. AFTER CHECKING THE METHOD OF APPLICATION THAT APPLIES TO YOU, *GO DIRECTLY TO THE GENERAL APPLICATION FORM.*

PRIVACY NOTIFICATION / NOTIFICACIÓN SOBRE PRIVACIDAD

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.tdh.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 522.021, 522.023 and 559.004)

Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.tdh.state.tx.us para más información sobre la Notificación sobre privacidad. (Referencia: *Government Code*, sección 522.021, 522.023 y 559.004)

ALL APPLICANTS MUST ATTACH THE CORRECT APPLICATION FEE PAID BY MONEY ORDER OR CERTIFIED CHECK. NO PERSONAL CHECKS. DO NOT SEND CASH.

GENERAL OR LIMITED CERTIFICATE	$75.00 APPLICATION FEE
TEMPORARY CERTIFICATE	$25.00 APPLICATION/CERTIFICATION FEE

DOCUMENTATION OF YOUR QUALIFICATIONS MUST BE SUBMITTED WITH THE APPLICATION

A. GENERAL CERTIFICATE. ***CHECK ONE OR NONE HERE***. ($75.00 application fee)

__ 1. Applicant was recognized as a Registered Technologist by the ARRT on September 1, 1987 AND is currently ARRT registered.

__ 2. Applicant was recognized as a Registered Technologist by the ARRT after September 1, 1987 AND is currently ARRT registered.

__ 3. Applicant was recognized as a Certified Nuclear Medicine Technologist by the NMTCB on September 1, 1987.

__ 4. Applicant was recognized as a Certified Nuclear Medicine Technologist by the NMTCB after September 1, 1987 AND is currently NMTCB certified.

__ 5. Applicant is currently licensed, certified, or registered to perform general radiography, radiation therapy or nuclear medicine technology in the state/territory of _____. NOTE: This item is NOT applicable for Texas, USA, ARRT, NMTCB, or any political subdivision other than a U.S. state, territory or District of Columbia. License, etc., must NOT be expired, temporary, or a limited type.

B. TEMPORARY GENERAL CERTIFICATE. *CHECK ONE OR NONE HERE*. ($25.00 application/certification fee) DO NOT CHECK ONE IF YOU CHECKED ANY ITEM IN PART A ABOVE. (Please read Item 14 of the General Application Form very carefully.)

__ 1. Applicant is a graduate of a JRCRTE accredited program in radiography, radiation therapy, or a JRCNMT accredited program in nuclear medicine technology.

__ 2. Applicant is expected to graduate from an accredited program in radiography, nuclear medicine or radiation therapy WITHIN 28 calendar days.

__ 3. Applicant has been determined as examination eligible by the ARRT or NMTCB. Applicant has attached a notarized copy of the examination eligibility letter.

__ 4. Applicant holds a current temporary license, certificate or registration to perform radiography, radiation therapy or nuclear medicine procedures, which was issued by the state/territory of _____. NOTE: This item is NOT applicable for Texas, ARRT, NMTCB, ARCRT or any other political subdivision other than a U.S. state, territory, or District of Columbia. Temporary license, etc., must NOT be expired or a limited type.

C. LIMITED CERTIFICATE. *DO NOT CHECK ANY ITEMS IF YOU CHECKED AN ITEM IN PART A OR B ON PAGE 1. DO NOT CHECK MORE THAN ONE ITEM IN EACH OF THE SECTIONS (1) - (8).*

1. ___ CARDIOVASCULAR CATEGORY. Applicant is a graduate of a JRCCVT accredited program and has successfully completed the RCVT exam.

2. ___ CHIROPRACTIC CATEGORY. Applicant is a graduate of a radiologic technology program (chiropractic category) approved by the Texas Department of Health and has passed the examination prescribed by the Texas Department of Health.

3. ___ PODIATRIC CATEGORY. Applicant is a graduate of a radiologic technology program (podiatric category) approved by the Texas Department of Health and has passed the limited examination (podiatric category) prescribed by the Texas Department of Health.

4. ___ SPINE CATEGORY. Applicant is a graduate of a radiologic technology program (spine category) approved by the Texas Department of Health and has passed the limited examination (spine category) prescribed by the Texas Department of Health.

5. ___ CHEST CATEGORY. Applicant is a graduate of a radiologic technology program (chest category) approved by the Texas Department of Health and has passed the limited examination (chest category) prescribed by the Texas Department of Health.

6. ___ EXTREMITIES CATEGORY. Applicant is a graduate of a radiologic technology program (extremities category) approved by the Texas Department of Health and has passed the limited examination (extremities category) prescribed by the Texas Department of Health.

7. ___ SKULL CATEGORY. Applicant is a graduate of a radiologic technology program (skull category) approved by the Texas Department of Health and has passed the limited examination (skull category) prescribed by the Texas Department of Health.

8.___ OUT OF STATE LICENSE. Applicant is currently licensed, certified, registered to perform LIMITED radiologic procedures in the state/territory of _____. NOTE: This item is NOT applicable for Texas, USA, ARRT, NMTCB, or any country or political subdivision other than a U.S. state, territory, or District of Columbia. CHECK the categories shown on your out-of-state limited license or certificate.

___ Chiropractic ___ Podiatric ___ Spine ___ Chest ___ Extremities ___ Skull

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D. TEMPORARY LIMITED CERTIFICATE. CHECK ONE OR NONE HERE.
IF YOU CHECK ANY ITEM IN PART A OR B ON PAGE 1, DO NOT CHECK ANYTHING IN THIS SECTION.

___ 1. Applicant is a graduate of a radiologic technology program (limited curriculum) approved by the Texas Department of Health or the Council on Chiropractic Education in the categories checked, as follows:

___ Chiropractic ___ Podiatric ___ Spine ___ Chest ___ Extremities ___ Skull

___ 2. Applicant is expected to graduate within 28 calendar days from a radiologic technology program (limited curriculum) approved by the Texas Department of Health or the Council on Chiropractic Education in the categories checked, as follows:

___ Chiropractic ___ Podiatric ___ Spine ___ Chest ___ Extremities ___ Skull

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E.___ PROVISIONAL CERTIFICATE. See Section 143.7(i) of the rules for requirements and documentation needed.

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AFTER YOU HAVE CHECKED THE METHOD OF APPLICATION, WHICH APPLIES TO YOU, GO DIRECTLY TO THE GENERAL APPLICATION FORM.

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NOTE: DO NOT SEND CASH THROUGH THE MAIL.

GENERAL APPLICATION FORM
TEXAS DEPARTMENT OF HEALTH
MRT PROGRAM
(512) 834-6617

BUDGET ZZ020
FUND 124

PERSONAL INFORMATION

1. Last Name First Name

2. Middle Name Maiden Name

3. Other Names Formerly Used

4. Mailing Address _____

City _____ State _____ Zip _____

Telephone Number (INCLUDE AREA CODE)_____

5. Permanent Address (If same as 4, WRITE SAME)

Month Day Year
6. Birthdate Birthplace

7. Social Security # (required by law, effective September 1, 1995) _____ - ____ -_____

8. Are you CURRENTLY employed? No Yes If "YES" YOU MUST complete (A) – (G).

NOTE: If you are performing radiologic procedures submit documentation that you are not in violation of the Medical Radiologic Technologist Certification Act, Texas Occupations Code, Chapter 601.
Do not perform radiologic procedures in Texas until this application is processed and a certificate or temporary certificate is issued.

(A) Place of Employment

(B) Address

(C) City State Zip

(D) Telephone Number (INCLUDE AREA CODE) Ext.

(E) Job Title Normal Working Hours _____ am to _____ pm

(F) Date of Employment (Month/Year)

(G) Do NOT answer if currently employed in radiologic technology.
Are you currently SEEKING employment in radiologic technology? Check one Yes No

9. Circle ONE number below which matches your PRIMARY employment setting (how you spend MOST of your time).
DO NOT CIRCLE MORE THAN ONE (1) CATEGORY.

1. Diagnostic - Hospital
2. Diagnostic - Physician's Office or Clinic
3. Diagnostic - Other Health Care Facility
4. Dentist's Office
5. Chiropractor's Office
6. Podiatrist's Office
7. Radiology Student
8. Radiology Educator
9. Management - Hospital
10. Management - Radiation Therapy Center
11. Management - Other Health Care Facility
12. Radiation Therapy - Hospital
13. Radiation Therapy - Free-standing Therapy Center
14. Radiation Therapy - Other Health Care Facility
15. Nuclear Medicine - Hospital
16. Nuclear Medicine - Other Health Care Facility
17. Radiologic Consultant - Self-Employed
18. Equipment and/or Product Distribution
19. Not Employed/Not Employed in Radiologic Technology
20. Mobile Unit
21. Imaging with Non-Ionizing Radiation (MRI/Ultrasound)
22. Other _____

10. WORK HISTORY (LIST LAST JOB FIRST)

FROM Mo. Yr.	TO Mo. Yr.	Total Yrs. Mos.	Job Title and Most Important Duties	Employer's Name and Address

PROFESSIONAL CREDENTIALS

11. Are you certified by a national organization (Registry) that attests to your competency as an operator of radiation or radiation emitting equipment? (Check Appropriate box) Yes No

If "Yes," list the name of that national organization(s) and your certificate number(s) below

SUBMIT A COPY OF THE CERTIFICATE WITH THIS APPLICATION FORM.

National Organization	Certificate Number	Type	Issue Date
National Organization	Certificate Number	Type	Issue Date

12. a) Have you ever held any type of certificate or license issued by the Texas Department of Health?
Yes No

b) Have you ever held a radiologic technology certificate or any other license from another U.S. state, territory or District of Columbia?
Yes No

c) If "NO," go to Question #13. If "YES," to #12a or b complete the following section and follow instructions on the "Other License/Certificate Documentation Form C" included with this application.

Indicate date form was mailed to State/Territory listed below:_____

State/Territory	Title of Certificate or License	Number	Issue Date & Expiration Date

13. Have you ever been registered as a radiologic technologist by any of these agencies:
Texas State Board of Medical Examiners, Texas State Board of Chiropractic Examiners,
Texas State Board of Podiatric Medical Examiners?
(check appropriate box) Yes No If "Yes," circle name of the agency above
and indicate the dates you were registered: _____

EDUCATIONAL INFORMATION

READ CAREFULLY: Applicants who are not recognized as registered/certified technologists by the ARRT, or NMTCB, must submit a copy of a high school diploma / transcript/ G.E.D. certificate (transcript must indicate graduation) OR college transcript (transcript must indicate admission as a high school graduate or that a degree was awarded).

14. Have you graduated from high school or passed a high school equivalency test (GED)?
(Check the appropriate box) High School Graduate G.E.D. No

If "No," proceed to Question #15. If "Yes," complete the following section.

(A) Your name at time of graduation or when GED was awarded

(B) Name of last high school attended

(C) Location of last high school City State

(D) Year of Graduation

15. Have you completed a degree at an accredited college or university? (Check appropriate item)
____ Yes ____ No

If "Yes," check appropriate type and complete items (A)-(D).
____ Associate ____ Bachelor's ____ Master's ___ Doctoral

(A) Your name at time of graduation

(B) Name of College or University

(C) Location of College or University

City State Zip

(D) Year of Graduation

RADIOLOGIC TECHNOLOGY EDUCATION

READ CAREFULLY: Applicants who are not recognized as registered/certified technologists by the ARRT, or NMTCB, must submit a copy of the diploma or certificate from the radiologic technology educational program. **Applicants who have not received their diploma or certificate may submit an "expected graduation statement" signed by the program director indicating the anticipated graduation date and the application must be postmarked before the graduation date.**

16. Name of School

City State Zip

Dates Attended From To

Type of Diploma Degree _____ Certificate Date awarded _____

Indicate the type of program in which you received your training in radiologic technology. (Check appropriate item)

__ RADIOGRAPHY

__ NUCLEAR MEDICINE TECHNOLOGY

__ RADIATION THERAPY TECHNOLOGY

__ LIMITED RADIOGRAPHER - (INDICATE CATEGORIES)

17. Have you ever been denied any license or certification or had any revoked, cancelled, or suspended?
(Check appropriate item) _____ Yes _____ No

If your answer is "Yes" to the above question, give a complete explanation on a separate sheet.

18. Have you EVER pled nolo contendere or been convicted of any crime other than a minor traffic violation?
__ Yes __ No

NOTE: If YES, a copy of the charges and disposition papers MUST be attached. Driving while intoxicated (DWI) is NOT a minor traffic violation.

APPLICANT'S CURRENT COLOR PHOTOGRAPH

19. Attach your passport size COLOR photograph here. (minimum size 1 1/2" x 1 1/2"). The photograph should be of the applicant's head and shoulders ONLY. Photograph must have been taken within six months previous to date of application. PRINT YOUR NAME ON THE BACK OF YOUR PICTURE.
Black and white pictures, cut-outs, newspaper clippings, sub-size pictures, photocopies, etc., WILL NOT BE ACCEPTED.

This photograph will be used in connection with your application for Examination for Certification and the purposes of complaint(s)/violation(s) investigations. All applications are open to the public under the Texas Public Information Act.

DECLARATION

20.READ CAREFULLY---THIS FORM MUST BE SIGNED AND POSTMARKED WITHIN 30 DAYS AFTER SIGNING.

(Applicant's printed name)

I, _____, declare that the statements herein contained are true in every respect. I have read and will abide by the rules and regulations relating to the certification of Medical Radiologic Technologists as specified in §143.1-143.20. I understand that ALL FEES ARE NON-REFUNDABLE. I understand that additional fees are required to be paid prior to issuance of and to renew any renewable certificate. I understand that successful completion of an examination and payment of all fees are required to upgrade a temporary certificate to a renewable certificate.

I agree to notify the department in writing within thirty (30) days of ANY CHANGE of name, address, or place of employment. I agree to return any certificate and identification card to the department upon the revocation, suspension or cancellation of that certificate. I further acknowledge that I am responsible for keeping the certification current in order to perform radiologic procedures on human beings for medical purposes. I agree to comply with the rules relating to renewal, continuing education and violations and subsequent actions.

Please note: Any information submitted on the application forms and any supporting documentation is subject to the Public Information Act. This means that anyone requesting copies of the information in your file or requesting to view your file will be able to do so.

Signature of Applicant _____

Date _____

SEND COMPLETED APPLICATION WITH ENCLOSURES AND CERTIFIED CHECK/MONEY ORDER TO:

Texas Department of Health
Attention: MRT Program
P.O. Box 12197
Capitol Station
Austin, Texas 78711-2197

F65-10710-Revised 01/2002

TEXAS MEDICAL RADIOLOGIC TECHNOLOGIST CERTIFICATION PROGRAM
OTHER LICENSE/CERTIFICATE VERIFICATION FORM

DO NOT SEND THIS FORM TO THE ARRT, ARCRT, NMTCB, OR OTHER NATIONAL CREDENTIALING AGENCY

PART I. APPLICANT Print or type all information.

Please complete Part I. and forward one form to each state, territory, or country in which you now hold or have ever held any professional license. **This form may be copied if extras are needed**.

NOTE: Some states require a fee, paid in advance, for providing this information. Applicants are responsible for paying any fees. You may wish to contact the agencies in advance.

I hereby authorize the licensing agency of the State of _____ to release any and all information on file concerning me, favorable or otherwise, to the Texas Department of Health, Medical Radiologic Technologist Certification Program.

APPLICANT'S NAME _____ Social Security Number _____

I was granted License number _____on _____ having an expiration date _____

_____
Signature

PART II. VERIFYING STATE

Please complete and return this form directly to the Texas Medical Radiologic Technologist Certification Program, 1100 West 49th Street, Austin, Texas 78756-3183.

The records of the licensing agency of the State of _____indicate that the above-named individual was issued license/certificate No._____ dated _____ on the basis of written examination (please name examination) _____; reciprocity with the State of_____; other basis (please state)_____. Type of license (radiologic technology, respiratory care, etc.)_____.

PLEASE ANSWER THE FOLLOWING QUESTIONS	Yes	No	Cannot Divulge
1. Is this license/certificate current?			
2. Is this license/certificate a limited or temporary type? (If yes, explain and/or remarks.)			
3. Is this license/certificate in good standing?			
4. Has this individual ever been warned or reprimanded?			
5. Has this individual's license/certificate ever been revoked?			
6. Has this individual's license/certificate ever been suspended?			
7. Has this individual's license/certificate ever been placed on probation?			
8. Has this individual's license/certificate ever been restricted in any manner?			
9. Has this individual ever had any charges filed against him/her?			
10. Do you know of any information that may be a discredit to this person?			
11. Do your files indicate any derogatory information whatsoever?			

REMARKS _____
_____
_____
_____

**This form must be signed and dated on page 2 (over)

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Date: _____ Signed: _____

Board Seal Title: _____

NAME AND ADDRESS OF LICENSING AGENCY

NOTE: Please attach certified copies of any pertinent material such as: Notice of Hearing, Final Decision, Consent Order/Agreement, etc., if the answer to Nos. 1 & 3 is no, or if the answer to 4-11 is yes.

Above signature must be notarized IF the agency does not have an official seal.

THE STATE OF _____)

COUNTY OF _____) SEAL

BEFORE ME, the undersigned authority, on this day personally appeared_____, known to me to be the person whose name, is subscribed to Part II of the foregoing instrument, and having by me first duly sworn to oath, acknowledged that she/he had executed the same for the purposes and considerations therein expressed and that the foregoing statements are true and correct.

GIVEN under my hand and seal of office, this _____ day of _____, _____

Notary Public in and for _____ County, _____

Notary Signature: _____

Printed Name of Notary: _____

My Commission Expires: _____

RETURN THIS FORM DIRECTLY TO:

TEXAS DEPARTMENT OF HEALTH
Attention: MRT Program
1100 West 49th Street
Austin, TX 78756-3183
(512) 834-6617